DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES	<u> </u>	19/12/ NITH 12/12/19	NTED: 10/05/2017 ORM APPROVED
I AND FUAN OF CORRECTION I INCATION AUTOMATICATION AUTOMATICATION AUTOMATICATION AUTOMATICATION AUTOMATICATION		(X2) MULT A. BUILDIN	3 NO. 0938-0391 3) DATE SURVEY COMPLETED		
		445244	B. WING _		<u>:</u> 10/03/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LIFE C	RE CENTER OF CLEV	ELAND	ĺ	3530 KEITH ST NW CLEVELAND, TN 37311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
K 000	INITIAL COMMENT	-s	K 00	0	
;     	of Tennessee Depa Health Licensure ar Care Facilities surve Safety Survey, Life- found not in substar requirements for pa Medicare/Medicaid Life Safety from Fire	y was conducted by the State rtment of Health Division of a Regulation Office of Health by on 10/3/17. During this Life Care Center of Cleveland was nitial compliance with the rticipation in at 42 CFR Subpart 483.70(a), and the related National ocietion (NFPA) Standard 101			
K 131	NOT MET as evider NFPA 101 Multiple (		K 13	1 K131	
SS≃Ō	Multiple Occupancies Facilities Sections of health cother occupancies reactions.  * They are not intensing approved, supervise in accordance with 3 Hospital outpatients required to be classic Care Occupancy respatients served.  18.1.3.3, 19.1.3.3, 4 485,623 This STANDARD is	are facilitles classified as meet all of the following; ded to serve four or more of from areas of health care struction having a minimum are rating in accordance with its protected throughout by an ed automatic sprinkler system section 9.7.  Surgical departments are iffed as an Ambulatory Health gardless of the number of 2 CFR 482.41, 42 CFR not met as evidenced by: on and interview, the facility		1. a) On October 10, 2017, the maintenance staff reconnected all the existing hardware to the fire doors in the breezeway separation between the ACLF and the Nursing Home. Or October 10, 2017, outside Contracted Simplex, came to the facility and properly sealed the holes in the fire door to meet Life Safety standards.  2. a) On October 10, 2017, the maintenance staff audited all facility fire doors to ensure no others had any missing hardware or holes. No others were affected by the alleged deficient practice.	1
ABORATOR	March NA Inc.	ER/SUPPLIER REPRESENTATIVE'S SIGNA	NTURE	TITLE	(X8) DATE
	THIN FOUR	<u> </u>		Executive Director	10-23-17

Any deficiency statement ending with an asterlak (\*) denotes a deficiency which the matitution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Facility ID: TN0802

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER;			A. BUILDING	(X3) DATE SURVEY COMPLETED			
	<b>-</b>	445244	B. WING		401001		
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	10/03/2017			
LIFE CA	RE CENTER OF CLE	VELAND	I	3530 KEITH ST NW			
				CLEVELAND, TN 37311			
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET		
K 131	Continued From pa	ane 1	16 404				
•	failed to maintain the	ne occupancy separation 2	K 131	3. a) The Maintenance staff will aud	lit		
	hour fire wall asser	nbly. This deficiency affected		fire doors weekly going forward usin	g		
	1 of 11 smoke com	partments,		the facilities TELS system.	10/27/17		
	NEDA 404 40 T.C			4. a) Maintenance Director will			
	NFPA 101, 19.7.6	1/2)		present the results of the audit to the	е		
I	NFPA 101, 19.1.3.3	0(4)		Performance improvement			
	The finding include	<b>s</b> ;		committee.			
	Observation and in	terview with the maintenance		b) The performance committee			
•	director on 10/3/17 at 1:37 PM revealed the two			consisting of the Executive Direct	tor,		
	hour separation fro	m the assisted living 90		Director of Nursing, Medical			
	minute fire door he	d through holes in the top of		Director, Director of Rehabilitatio	Π,		
	door and the door o	lid not latch due to the strike		Director of Maintenance, Director			
	plate being remove	d.		Environmental Services, Busines			
	The maintenance d	irector was present when the		Office Manager, Director of			
	deficiency was iden	tified and was acknowledged		Activities, Staff Development			
1	by the administrator	r during the exit conference on					
•	10/3/17.			Coordinator, will review the resul	ts.		
K 281 SS=E	NFPA 101 /Illuminat	ion of Means of Egress	K 281	If it is deemed necessary by the Performance Improvement			
	Illumination of Mear	ns of Egress		Committee, additional education			
	Illumination of mean	ns of earess, including exit		may be provided, the process/			
	discharge, is arrang	led in accordance with 7.8 and		revised, and or the audits reviewe	ed		
	snall be either conti	nuously in operation or		for three months or until 100%	**		
	intervention.	c operation without manual		compliance is achieved.	10/27/17		
	18.2.8, 19.2.8			estimated to deliloror.	19121111		
	This STANDARD IS	not met as evidenced by:					
,	Based on observati	ion, the facility failed to ensure		K281			
	illumination of mean	is of egress shall be		1. a) On October 4, 2017, the			
ı	continuously in oper	ation per the requirements of:			nt.		
				maintenance staff replaced the night			
	NFPA 101, 2012 Ed	Ition 19.2.8, 7.8		light bulbs in rooms 39, 45, 53, 57, 60.	and 10/27/17		
!	The deficiency affect	ted 3 of 11 smoke			, , , , , , , , , , , , , , , , , , , ,		
	compartments.						

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Event ID: B52E21

Facility ID: TN0602

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/05/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 01 COMPLETED 445244 B. WING 10/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF CLEVELAND 3630 KEITH ST NW CLEVELAND, TN 37311 (X4) IDI SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY K 281 Continued From page 2 K 281 2. a) On October 4, 2017, the maintenance staff audited all facility night The findings include: light bulbs. No others were affected by the alleged deficient practice. Observation with maintenance, on 10/3/17 10/27/17 between 12:45 PM and 2:30 PM revealed 3. a) The maintenance staff will audit emergency lighting failed to be in continuous night light bulbs monthly going forward operation in resident rooms 39, 45, 53, 57, and using the facility TELS system. 60. 10/27/17 4. a) Maintenance Director will present Maintenance was present when the deficiencies the results of the audit to the were identified and acknowledged by the administrator during the exit conference on Performance improvement committee. 10/3/17. b) The performance committee K 363 NFPA 101 Corridor - Doors K 363 consisting of the Executive Director, SS≂Ð Director of Nursing, Medical Director, Corridor - Doors 2012 EXISTING Director of Rehabilitation, Director of Doors protecting corridor openings in other than Maintenance, Director of Environmental required enclosures of vertical openings, exits, or Services, Business Office Manager, hazardous areas shall be substantial doors, such Director of Activities, Staff as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least Development Coordinator, will review 20 minutes. Doors in fully sprinklered smoke the results. If it is deemed necessary by compartments are only required to resist the the Performance Improvement passage of smoke. Doors shall be provided with a Committee, additional education may means suitable for keeping the door closed. be provided, the process/revised, and There is no impediment to the closing of the doors. Clearance between bottom of door and or the audits reviewed for three months floor covering is not exceeding 1 Inch. Roller or until 100% compliance is achieved. 10/27/17 latches are prohibited by CMS regulations on

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corridor doors and rooms containing flammable or combustible materials. Powered doors

complying with 7.2.1.9 are permissible. Hold open

devices that release when the door is pushed or

pulled are permitted. Nonrated protective plates

Door frames shall be labeled and made of steel

of unlimited height are permitted. Dutch doors

meeting 19.3.6.3.6 are permitted.

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Facility ID: TN0602

closure.

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10/27/17

1. a) On October 4, 2017, the

maintenance staff adjusted patient

room corridor doors 82, 98, and 101 to

the doors. Some hinges were replaced

and others adjusted to ensure correct

close to a positive latch upon closing

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STATEMEN	T OF DEFICIENCIES	(VA) PROPERTY OF TRACE	T	<u></u>	<u>NR NO: 0938-0391</u>	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		445244	B. WING		10/03/2017	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF CLEVELAND				STREET ADDRESS, CITY, STATE, ZIP CODE 3530 KEITH ST NW	10/03/2017	
064 15	COMMANDY NY			CLEVELAND, TN 37311		
(X4) IDI PREFIX TAG	(EACH DEFICIENCY	C'EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	AE COMPLÉTION	
κ 920	the smoke compart window assemblies sprinklered comparrestrictions in area of frames in window a 19.3.6.3, 42 CFR P and 485 Show in REMARKS protection ratings, a etc.  This STANDARD is Based on observation failed to maintain confidence of 11 smooth of the findings included the confidence of 10/3/17 is 2, 98, and 101 eith excessive force to confidence on 10/3/NFPA 101 Electrical and Extens  Electrical Equipment Extension Cords	n compliance with 8.3, unless ment is sprinklered. Fixed fire are allowed per 8.3. In the there are no or fire resistance of glass or ssemblies.  arts 403, 418, 460, 482, 483, and details of doors such as fire automatics closing devices, and met as evidenced by: ion and interview, the facility pridor doors. This deficiency oke compartments.  5  erview with the maintenance revealed resident room doors are failed to latch or required allose to a positive latch.  rector was present when the entifled and was a administrator during the exit 17.  Equipment - Power Cords  t - Power Cords and	K 3	63 2. a) On October 4, 2017, the maint staff audited all facility corridor doors verify the corridor doors throughout if facility will close to a positive latch, others were affected by the alleged deficient practice.  3. a) The Maintenance staff will auditerridor doors monthly going forward the facilities TELS system to ensure closure.  4. a) Maintenance Director will present the results of the audit to the Performing rovement committee.  b) The performance committee consisting of the Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Maintenance, Director of Environme Services, Business Office Manager, Director of Activities, Staff Developm Coordinator, will review the results. If deemed necessary by the Performal Improvement Committee, additional education may be provided, the procrevised, and or the audits reviewed for the sudits	s to the No 10/27/17  lit d using proper 10/27/17  sent mance f, f intel ment litts nce cess/ for	
	used for component	tlent care vicinity are only s of movable electrical equipment				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY		
			A. BUILDING 01 - MAIN BUILDING 01			MPLETED	
<u> </u>		445244	B. WING		1 40	100 los 4 -	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF CLEVELAND			STREET ADDRESS, CITY, STATE, 21P CODE 3530 KEITH ST NW	<u> </u>	/03/2017		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		CLEVELAND, TN 37311	<u> </u>		
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER CORRECTION DEFICIENCY)	D RE	(XS) COMPLETION DATE	
K 920	Continued From page	ne 4	14.00	K920			
	- dilimand i (bill ba	s that have been assembled	K 9:	<sup>20</sup> 1. a) On October 4, 2017, the			
1	by qualified persons	nel and meet the conditions of		maintenance staff removed all nor	n-		
	10.2,3.6. Power str	ips in the patient care vicinity		medical items that were in use wit	h the		
1	may not be used for	'non-PCREE (e.g., personal		power strips in rooms 40, 59, and	56. In		
·	electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power			rooms 45 and 60 the 1363 power			
				were removed completely and will	be		
	strips for non-PCRE	E in the patient care rooms		replaced with quad receptacles.		10/27/17	
	(Outside of vicinity) r	neet UL 1363, In non-patient		<ol><li>a) On October 4, 2017, the</li></ol>		10/2///	
ļ	standards All nows	strips meet other UL er strips are used with general		meintenance staff audited all facili	ity		
ı	precautions. Extens	sion cords are not used as a		power strips. No others were affect	ted by		
1	substitute for fixed y	viring of a structure.		the alleged deficient practice.		10/27/17	
i	Extension cords use	d temporarily are removed		<ol><li>a) The maintenance staff will a</li></ol>			
	which it was installed	empletion of the purpose for d and meets the conditions of		power strips monthly going forward	d using		
!	10.2.4.	d and meets the conditions of		the facilities TELS system.		10/27/17	
t	10,2,3,6 (NFPA 99),	10.2,4 (NFPA 99), 400-8		<ol><li>a) Maintenance Director will pre</li></ol>		:	
(NEPA 70), 590,3(D)		(NEPA 70) TIA 12-5		the results of the audit to the Perfo	rmance		
	This STANDARD is not met as evidenced by: Based on observation and record review, the			Improvement committee,			
	facility failed to provi	de power strips in patient		b) The performance committee			
	care areas for patier	it-care-related electrical		consisting of the Executive Direct			
1	UL 1363A or UL 606	and non-PRCREE that meet 01-01 for PCREE and UL		Director of Nursing, Medical Director			
•	1363 for non-PRCREE per the requirements of:			Director of Rehabilitation, Directo			
	NEPA 99 2012 Editio	on 10.2.3.6, 10.2.4, NFPA 70		Maintenance, Director of Environ			
	400-8 & 590,3 (D)	70.2.0.0, 10.2.4, NFFA /U		Services, Business Office Manag		ĺ	
•	This deficiency =	hand the action is a		Director of Activities, Staff Develo	· 1		
	This deficiency affect compartments.	red 3 of 11 smoke		Coordinator, will review the result			
	•			deemed necessary by the Perform			
	The findings include:			Improvement Committee, addition			
1	Observation and record review with maintenance on 10/3/17 between 12:47 PM and 2:30 PM revealed power strips not being used or located correctly in the following areas;			education may be provided, the p		j	
				revised, and or the audits reviewe			
				three months or until 100% compl	lance is	}	
RM CMS 064	7/02-00\ Previous Versions C	<u>-</u>	·	achleved.	1	10/27/17	

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Event (D: 852E21

Facility ID: TN0802

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2017 FORM APPROVED OMB NO. 0938-0391

CTAYCACAD	CONTRACTOR OF THE	TENEDICKID DERVICES	<del></del>		O	MB.	<u>NO. 0938-0391</u>
STATEMENT OF DEFICIENCIES (XI AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				DATE SURVEY COMPLETED
445244		B. WING			1.	4010010014	
NAME OF	PROVIDER OR SUPPLIER			Si	REET ADDRESS, CITY, STATE, ZIP CODE	<del>++</del> -	10/03/2017
LIFE ÇAI	RE CENTER OF CLEV	/ELAND			30 KEITH ST NW	•	
<del></del> -		·		CI	LEVELAND, TN 37311		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TÉMENT OF DEFICIENCIES  MUST BE PRÉCEDED BY FULL  SC IDENTIFYING INFORMATION)	IO PREF TAG	1X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	) RE	(X5) COMPLETION E DATE
K 920	Continued From pa	ge 5	K	920	-		
	1. Resident rooms	40, 49 and 56, have personal					
	Items plugged into a	Power strip rated UL 1363A					
	A 1363A or UL 6060 only for medical equ	)1-1 power strip is Jioment.					i
1	<ol><li>Resident rooms 4</li></ol>	45 and 60, have UL 1363					
1	bed. UL 1363 powe	d at the head of the resident r strips can only be used					
	for personal items of care.	outside the vicinity of patient					
:	Maintenance was p	resent when the deficiencies					
,	were identified and :	acknowledged by the the exit conference on					
					•		
							1
							ľ
					•		

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